

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034940

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 325

FILED OCT 14 1963

## 1. PLACE OF DEATH

a. COUNTY **Adair**

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN **Kirkville**

Length of stay in 1b  
**10 years**

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION **Kirkville  
Community Home #2**

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **Missouri** b. COUNTY **Adair**

c. CITY OR TOWN **Baring**

Inside Limits  
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)  
**Reside on Farm**  
Yes ☐ No ☐

## 3. NAME OF DECEASED

First Middle Last  
**Mary Ellen Gastineau**

4. DATE OF DEATH  
Month Day Year  
**Sept. 30, 1963**

## 5. SEX

**F**

## 6. COLOR OR RACE

**W**

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH  
**12/15/1871**

9. AGE (last birthday)  
**92**

IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Retired**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)  
**Cleveland, Ohio**

12. CITIZEN OF WHAT COUNTRY  
**U. S. A.**

## 13a. FATHER'S NAME

**Israel Teeters**

## 13b. MOTHER'S MAIDEN NAME

**Milinda Pulse**

## 14. NAME OF HUSBAND OR WIFE

**Tom Gastineau**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)  
**no**

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

### IMMEDIATE CAUSE (a)

**Bronchopneumonia**

INTERVAL BETWEEN ONSET AND DEATH  
**days**

### DUE TO (b)

**Cochesia of Debilitation**

**months**

### DUE TO (c)

**Generalized Arteriosclerosis**

**years**

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

**Chronic Bronchitis/Asthma/Emphysema**

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT ☐

SUICIDE ☐

HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **August 1, 1963** to **Sept 29, 1963** and last saw her alive on **Sept 29, 1963**  
Death occurred at **11:15** **A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

## 22b. ADDRESS

## 22c. DATE SIGNED

**Georgette Schenker, M.D.**  
**Burial**

23b. DATE  
**Oct. 2, 1963**

23c. NAME OF CEMETERY OR CREMATORY  
**Mt. Pleasant Cemetery**

23d. LOCATION (City, town, or county)  
**Labelle, Missouri**

(State)

## 24. FUNERAL DIRECTOR

**GERTH & BASKETT**

## ADDRESS

**MEMPHIS, MO.**

## 25. DATE RECD. BY LOCAL REG.

**Oct 5, 1963**

## 26. REGISTRAR'S SIGNATURE

**Doris W. Ratliff**

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
1 0017  
2 0017  
3  
4 1  
5 2  
6  
7 1  
8 2  
9 4500  
10  
11  
12 86-2  
13 10

permit raised Sept 30, 1963

GEORGE H. SCHNEURER, D.D.

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.